STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155715	A. BUILDING 00 B. WING	09/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00132376. Complaint IN00132376 - Unsubstantiated due to lack of evidence. Survey dates: September 3, 4, 5, 6, 8, 9, and 10, 2013 Facility number: 000347 Provider number: 155715 AIM number: 100275440 Survey team: Diana Sidell RN, TC Sunny Jungclaus RN (September 3, 4, 5, 6, 9, and 10, 2013) Jennifer Carr RN (September 3, 4, 5, 6, 9, and 10, 2013) Debora Barth RN (September 3, 4, 5, and 6, 2013) Debora Kammeyer RN (September 3, 4, 5, and 6, 2013) Census bed type: SNF/NF: 99 Residential: 35 Total: 134	F000000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census payor type: Medicare: 12 Medicaid: 56 Other: 66 Total: 134 Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on September 19, 2013, by Cheryl Fielden, RN			

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F000156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure liability and appeal notices were given in a timely manner for 3 of 3 residents who fit the criteria for liability notices. (Residents #11, #26, and #127) Findings include: 1. During an interview, on 09/05/13 at 8:51 a.m., the Administrator indicated that the Notice of Medicare non-coverage for Resident #11 could not be found. She indicated that the Social Services Department could not remember getting it signed and further stated that "It is normally in the medical record." 2. On 09/05/13, the Notice of Medicare Non-Coverage letter for Resident #26 was reviewed. The notice indicated that Resident #26's medicare services would end on 4/26/13. The letter was signed by Resident #26 on 04/25/13. An interview, on 09/5/13 at 2:30 p.m., with the Admission Coordinator indicated that this was a one day notification.	F000156	F 156 Notice of Rights, Rules, Services, and Charges (Medicare Non-Coverage Letters)It is the policy of this facility to ensure liability and appeal notices are given in a timely manner.Corrective Action For Resident Affected: Residents #11, 26, and 127 were already discharged from the facility at the time of survey.Other Residents Having The Potential To Be Affected: All residents with Medicare benefits have the potential to be affected.Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: The Admissions Director who is responsible for these notices completed her Social Service Designee course on 08/09/2013. She received training on these notices in that training. Appropriate members of the leadership team were provided a written copy of the instructions for use of the Notice of Medicare Non-Coverage Letter. (Attachment 4 titled Form Instructions for the Notice of Medicare Non-Coverage). All members verbalized understanding of the requirements and signed off on the form. All future notices shall be provided in accordance to the CMS form instructions. (Attachment 5 titled Notice of Medicare Non Coverage Letters Education). Monitoring of	10/07/2013

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	3. On 09/05/13, the Notice of Medicare Non-Coverage letter for Resident #127 was reviewed. The notice indicated that Resident #127's medicare services would end on 06/14/13. The signature line, dated 06/12/13, was noted "received verbal confirmation from , that he is aware[Resident #127's son] of [Resident #127's] skilled /OT Tx (occupational therapy) services ending but continuing a RNP (restorative nursing program) on Speech Tx (Therapy)." An interview, on 09/05/13 at 2:30 p.m., with the Admissions Coordinator, indicated she only had the verbal ok and no further documentation. 4. Interview with the Admission Coordinator, on 9/5/13 at 2:40 p.m., indicated she had not given any resident an estimate of costs when the resident was discharged from Medicare, but remained in the facility. She also indicated none of the residents had asked for a demand bill. 5. On 09/06/13, at 11:28 a.m., the facility "Form Instructions for the Notice of Medicare Non - Coverage (NOMNC) CMS - 10095" was reviewed. The first sentence of this form reads, "A Medicare health		Corrective Action: All discharged records will be reviewed to ensure that the appropriate notice was given in the appropriate time frame. This audit will begin with all discharges in the month of October. (Attachment 6 titled Medicare Non Coverage Letters Discharge Audit). Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate documentation is in the record 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audit, a full audit will resume. If after six months of random audits 100% compliance continues, auditing will stop.	

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	provider must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursing...no later than two days before the termination date to the provider not later than two days before the termination of services." 3.1-4(f)(3)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a care plan related to catheter use for 1 of 19 residents reviewed. (Resident #28) Finding include: The clinical record for Resident #28 was reviewed on 09/06/13, at 10:07 a.m. The record indicated the resident was admitted, on 02/23/13, with diagnoses that included benign prostatic hypertrophy and urinary retention. A progress note dated	F000279	F 279 Comprehensive Care Plans. It is the policy of this facility to use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care.Corrective Action for Resident Affected: The resident's care plan was reviewed and a care plan for use of a Foley catheter was added to the resident's plan of care. (Attachment 7 titled Foley Catheter Care Plan) .Other Residents Having the Potential to be Affected: All residents with catheters have the potential to be affected. The care plans of the	10/07/2013

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	03/24/13 indicated a bladder scan was performed at 8 a.m., and the post void showed a residual of 380 milliters. After follow up with the physician, an order was received on 03/25/13 for: "Urinary retention anchor tonite then call [physician's name] in am for further instructions." Review of the Treatment Administration Record indicated documentation for monthly change for foley catheter per orders. The record did not include a care plan related to the foley catheter. An interview with the DON, on 09/05/2013 at 4:32 p.m., indicated that she is unable to find a plan of care for the foley catheter for Resident #28. 3.1-35(a)		residents with catheters were audited to assure the presence of a care plan for the use of a catheter. Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: During review of new and admission orders each business day, DON or designee will assure a care plan has been initiated for any residents with a new order for a catheter. An audit of care plans of residents with catheters will be completed weekly to assure an appropriate care plan for catheter use is in place. (Attachment 8 titled Catheter Care Plan Audit). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate documentation is completed 100% of the time, weekly audits will be stopped and monthly audits will begin. A sample size of 25% will be completed. If opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100% compliance continues, auditing will stop.	

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observations, interviews and record review, the facility failed to reposition 1 of 2 residents in a sample of 35 reviewed for positioning. (Resident #52) Findings include: On 9-3-13 at 10:01 A.M., Resident #52 was observed sitting in a wheel chair in the activity/dining room. The resident's wheel chair had a foam cushion and alarm, and was pulled close to the table. The resident was observed to be in the same position and in the same area at 10:30 A.M., 11:15 A.M., 12:01 P.M.,12:33 P.M. and at 2:35 P.M. on 9-3-13. On 9-4-13 at 9:25 A.M., the resident was observed sitting in a wheel chair, at the same table in the activity/dining room being assisted with eating her breakfast. On 9-4-13 at 10:00 A.M., the resident was observed in the activity-dining	F000312	F 312 ADL Care Provided For Dependent Residents. It is the policy of this facility to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, personal hygiene, and oral hygiene.Corrective Action for Resident Affected: The careplan of resident #52 was reviewed to assure the turning and/or repositioning approach was included in the care plan. The nurse orders for this resident were reviewed to assure turning and repositioning nurse orders were in place and sent to the C.N.A. task list in Optimus. This resident will be included in the audit described below at least once per week. If the audit changes to weekly, then this resident will be included in the audit at least once per month.Other Residents Having the Potential to be Affected: Each resident dependent upon staff for turning and/or repositioning has the potential to be affected. The care plans of these residents were reviewed to assure the turning and repositioning approach was included in the skin	10/07/2013

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	room, sitting in her wheel chair, with chair alarm and foam cushion in place. A stuffed dog and some scarf's were placed in front of her. The resident was continually observed in her wheel chair on 9-4-13 from 10:40 A.M. thru 11:45 A.M. in the same position. The resident was not repositioned throughout this observation period. An interview, on 9-4-13 at 11:45 A.M., was conducted with CNA #5 and CNA #6. Both CNA's indicated they had not taken Resident #52 to the restroom, changed her brief, nor changed her position. They both further indicated the resident was a two person assist. On 9-4-13 at 1:53 P.M., the resident was observed sitting in her wheel chair in the dining/activity room. On 9-4-13 at 3:30 P.M., the resident was observed in her wheelchair, at the table, in the dining/activity room. On 9-4-13 at 3:40 P.M., a careplan dated 1-21-13 was reviewed, and indicated the resident was at risk for skin breakdown related to: decreased mobility, cognitive deficit and diabetes. Interventions included but		care plan. The nurse orders of each of these residents were reviewed to assure turning and repositioning nurse orders were in place and sent to the C.N.A. task list in Optimus, the electronic medical record. Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: Nursing staff education was initiated beginning September 25, 2013 and will be complete by 10-07-2013. (Attachment 9 titled 2013 Annual Survey Plan of Correction). An audit will be conducted each business day on one randomly selected resident to assure appropriate documentation of turning and/or repositioning is completed. In addition, that resident will be checked visually at multiple random times during the business day to assure a position change has occurred. (Attachment 10 titled Turning and/or Repositioning Audit). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate care and documentation is completed 100% of the time, daily audits will be stopped and weekly audits will begin. A sample size of 25% will be completed. If opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100%	

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	were not limited to: assist resident to turn and reposition every 2 hours and as needed, encourage resident to get out of bed daily, keep resident clean and dry, pressure reducing cushion on wheelchair, and pressure reducing mattress. On 9-5-13 at 4:07 P.M. a review of the form "CNA Tasks Completed" indicated the staff did not document that Resident #52 was repositioned between 7:00 A.M. and 3:00 P.M. on 9-3-13 and 9-4-13. An interview with the Administrator (ADM), on 9-5-13 at 4:10 P.M., indicated Resident # 52 wasn't repositioned from 7 A.M. to 3 P.M. per CNA documentation on 9-3-13 and 9-4-13. The ADM had no explanation as to why the resident wasn't reposition by the staff every 2 hours as the careplan/nursing orders directed. 3.1-38 (3)(b)(6)		compliance continues, auditing will stop.	

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to prevent the possible excessive use of Tylenol with a precautionary statement for 2 of 5 residents reviewed for unnecessary medications. (Residents #20 and 68) Findings include: 1. The clinical record for Resident # 20 was reviewed on 9/4/13 at 2:30 p.m. for medication use. The resident had diagnoses which	F000329	F 329 Unnecessary Drugs (Tylenol Precautionary Statement).It is the policy of this facility that each resident's drug regimen must be free from unnecessary drugs. Corrective Action for Residents Affected: Orders for all medications containing acetaminophen for resident #20 and #68 were reviewed. PRN administration was reviewed for these residents over a 30-day period and was calculated with any routine medication doses. There were no instances of exceeding the daily	10/07/2013

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	included, but were not limited to: stroke, intractable pain, and osteoarthritis. The most recent physician rewrite orders, dated 7/6/13, indicated the medications included, but were not limited to the following: Tylenol Extra Strength 500 milligrams (mg) one capsule daily (original order date was 5/6/13); Tylenol 325 mg 2 tabs prn (as necessary) q4h (every 4 hours) for pain or fever (original order date was 5/6/13); and Tylenol Arthritis 650 mg 2 tabs q8h prn up to 3 times per day for pain (original order date was 5/6/13). The Medication Administration Record (MAR) for June, 2013 July, 2013 and August, 2013 were reviewed. The MAR indicated the resident had received the prn Tylenol only one time on 8/25/13 during the three months reviewed. There were no precautionary statements for what would constitute and excessive dose for the resident on any of the orders or in the residents chart. The pharmacist had reviewed the resident's medication orders on 5/28/13 and 6/24/13 with no Tylenol recommendations. 2. The clinical record was reviewed		recommended limit of 4000mg. A precautionary medication test with the statement “Do not exceed 4000mg of acetaminophen daily “ was added to the EMR system to attach to medications containing acetaminophen. This medication test was added to each medication containing acetaminophen for these residents. (Attachment 11 titled Medication Test Example). A care plan for acetaminophen use was added to each resident’s plan of care. (Attachment 12 titled Acetaminophen Warning Care Plan). Other Residents Having the Potential to be Affected: All residents taking acetaminophen have the potential to be affected. The medication orders for all residents were reviewed for usage of acetaminophen. Those residents with the potential to exceed 4000mg daily based upon their routine orders in addition to use of every prn dose available were identified. PRN administration was reviewed for these residents over a 30-day period and was calculated with any routine medication doses. There were no instances of exceeding the daily recommended limit of 4000mg. A precautionary medication test with the statement “Do not exceed 4000mg of acetaminophen daily” was added to the EMR system to attach to medications containing	

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	on 9/5/13 at 8:55 a.m. for Resident # 68. He had diagnoses which included, but were not limited to: hypertension, peripheral neuropathy, insomnia, osteoarthritis, glaucoma, and dementia. The physician rewrite orders for medications, most recently reviewed by the physician on 8/3/13, indicated the resident was receiving Norco 5/325 (5 milligrams [mg.] of Hydrocodone and 325 mg of Tylenol) 1 tablet q4h (every 4 hours) for pain (originally ordered 8/22/12). In addition, there was an order for Tylenol 325 2 tabs q4h prn (as necessary) (originally ordered on 8/22/12). The Medication Administration Record (MAR) for July, 2013, August, 2013, and September, 2013 was reviewed. The resident had received prn Tylenol once each day on 7/27/13, 8/6/13, 8/11/13, 8/27/13, and 9/13/13. 3. Review of the Nursing 2013 Drug Handbook, from the A Unit of the facility, on page 67, indicated the following: "...Indications and dosages: Adults: 325 to 650 mg every 4 to 6 hours. Or, two extended-release caplets P.O. (by		acetaminophen. This medication test was added to each medication containing acetaminophen for each of these residents. A care plan for acetaminophen use was added to each resident's plan of care.Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: A medication test with the precautionary statement "Do not exceed 4000mg of acetaminophen daily" was added to the EMR system. During review of new and admission orders, DON or designee will assure the medication test with the precautionary statement is attached to any orders for medications containing acetaminophen. An audit of 6 residents per week will be conducted to assure they have not exceeded the recommended daily dosage limit. (Attachment 13 titled Acetaminophen Audit). Nursing staff education was initiated on September 25, 2013 and will be complete with all staff by 10-07-2013. (Attachment 9 titled 2013 Annual Survey Plan of Correction). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate documentation is completed 100% of the time, weekly audits will be stopped and monthly audits will begin. A sample size of 25% will be completed. If	

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	mouth) every 8 hours. Maximum , 4 g (grams) daily. For long term therapy, don't exceed 2.6 g daily unless prescribed and monitored closely by health care provider...." 4. Interview with the Director of Nursing, on 9/5/13 at 10:30 a.m., indicated she had contacted the pharmacist. She indicated he had indicated he did not recommend a precautionary statement until the resident was close to or over the recommended dose. 3.1-48(a)(1)		opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100% compliance continues, auditing will stop.	

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure 98 of 99, receiving food served from the dining room were served food in a sanitary manner regarding clean steam tables, hand washing and glove use. Findings include: 1. During the entrance tour kitchen observation, on 9/3/13 at 7:30 a.m., Cook # 7 was serving breakfast trays. She removed her gloves, left the kitchen, then returned and washed her hands for approximately 5 seconds. She returned to the serving line and returned to dipping the food. Cook # 7 was again observed on the B unit serving breakfast on 9/3/13 at 8 a.m. She handled bread while wearing gloves, making toast. She then scooped food onto plates, then retrieved the bread from the toaster. She grabbed a squeeze bottle of jelly on the cart while wearing the same	F000371	F 371 Food Procure, Store/Prepare/Serve - Sanitary.It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities and to store, prepare, distribute, and serve food under sanitary conditions.Corrective Action of Resident Affected: No residents were affected.Other Residents Having the Potential to be Affected: All residents in the facility have the potential to be affected.Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: Staff education was provided to the Dietary staff on September 11, 2013 and with all of the nursing staff beginning September 25, 2013 and will be complete by 10-07-2013. Content of the education included review of Standard Precautions policy, Food Service Sanitation policy and general glove use and hand washing. (Attachment 14 titled Infection Control - Food Handling). Monitoring of Corrective Action : Random dining room audits will be	10/07/2013

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	gloves. Still wearing the gloves, she squeezed jelly onto toast, cut the toast, placed it on a plate and served it to a resident. She continued to wear the same gloves while serving food on the B wing to the residents in the assist dining room. 2. Interview with the Dietary Manager, on 9/5/13 at 1:30 p.m., indicated the cook should have removed her gloves and washed her hands before handling food after handling the jelly bottle. She also indicated the staff knew they should wash their hands for at least 20 seconds. 3. On 9-3-13 at 12:00 P.M., CNA #1 was observed in the dining room, donned gloves, and touched papers with diet instructions on it. CNA #1 walked over to a resident's table and leaned over the table, placing her right gloved hand on the table. CNA # returned to steam table and began to dish out meal portions for multiple residents. CNA #1 left the area and returned with no gloves on her hands. She donned gloves and took a plastic seal off several prepared pies. CNA		completed weekly that will cover the main dining room and all satellite dining areas. The Dietary Manager will also complete daily audits five days per week in the kitchen. (Attachment 15 titled Dietary Observation Tool). Audit results will be reviewed by the Quality Assurance Committee monthly for three months. If appropriate practice is observed 100% of the time, daily audits will be stopped and random audits will begin weekly. If opportunities for improvement are identified through the weekly audit, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop.	

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	#1 cut the pies and served them, moving a resident's silverware with her gloved hands. CNA #1 returned to the steam table and began to serve other residents. CNA #1 removed gloves and did not wash her hands after removing the gloves. CNA #1 returned to the kitchen counter and took the plastic seal off a pie, cut the pie and served the pie without gloves on. When she had completed serving, she sat down next to a resident to assist in feeding him. 4. On 9-5-13 at 9:05 A.M., a review of a policy titled "Standard Precautions" indicated "...Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments." 5. On 9-6-13 at 9:40 A.M., a review of the policy titled "Procedure for glove use" indicated "...You are to change into clean gloves anytime you go to do other job duties...." 6. On 9-6-13 at 9:50 A.M., a review of the policy titled "Food Service Sanitation" indicated "...4. Plastic gloves are useful when the hands will			

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	be in direct contact with food or when there is a sore or burn on the hand. Plastic gloves may also become contaminated, like the hand, and should be replaced with clean gloves when this occurs...." 7. On 9-3-13 at 12:02 P.M., the steam table on the dementia unit had an old dried substance on it prior to serving the lunch meal. The plastic hood also had a dried food substance on it. There were 29 residents in the dementia area being served from the steam table. During an interview, on 9-3-13 at 12:35 P.M., CNA #1 indicated the dried substance on the steam tray was to be cleansed by the kitchen staff. She further indicated that she believed the steam tables were cleansed twice a day. 8. On 9-4-13 at 9:00 A.M., a review of a form titled "Cooks Help (Cleaning List) indicated "...take racks out of steamer and clean, then wipe out the steamer...." 9. On 9-6-13, at 11:20 P.M., a review of a policy titled "Food Service Sanitation - Equipment and Utensils - Cleaning and Sanitizing" indicated "...The food contact surfaces of grills,			

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	griddles, and similar cooking devices and the cavities and door seals of microwave ovens shall be cleaned at least once a day...The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil...." 3.1-21 (i)(3)			

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F000428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on record review and interview, the facility failed to ensure the pharmacist included precautionary statements for residents receiving tylenol on a regular and PRN (as needed) basis. This affected 2 of 5 residents reviewed for unnecessary medications. (Residents # 20 and 68) Findings include: 1. The clinical record for Resident # 20 was reviewed on 9/4/13 at 2:30 p.m., for medication use. The resident had diagnoses which included, but were not limited to: stroke, intractable pain, and osteoarthritis. The most recent physician rewrite orders, dated 7/6/13, indicated the medications included, but were not limited to the following: Tylenol Extra Strength 500 milligrams (mg) one capsule daily (original order date was 5/6/13); Tylenol 325 mg 2 tabs prn (as	F000428	F 428 Drug Regimen Review, Report, Irregular, Act On. It is the policy of this facility that the drug regimen of each resident is reviewed at least once per month by a licensed pharmacist and that reports are made and acted upon.Corrective Action for Residents Affected: Orders for all medications containing acetaminophen for resident #20 and #68 were reviewed. PRN administration was reviewed for these residents over a 30-day period and was calculated with any routine medication doses. There were no instances of exceeding the daily recommended limit of 4000mg. A precautionary medication test with the statement “Do not exceed 4000mg of acetaminophen daily “ was added to the EMR system to attach to medications containing acetaminophen. This medication test was added to each medication containing acetaminophen for these residents. (Attachment 11 titled Medication Test Example). Other	10/07/2013

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	necessary) q4h (every 4 hours) for pain or fever (original order date was 5/6/13); and Tylenol Arthritis 650 mg 2 tabs q8h prn up to 3 times per day for pain (original order date was 5/6/13). The Medication Administration Record (MAR) for June, 2013 July, 2013 and August, 2013 were reviewed. The MARs indicated the resident had received the prn Tylenol only one time on 8/25/13 during the three months reviewed. There were no precautionary statements for what would constitute an excessive dose for the resident on any of the orders or in the resident's chart. The pharmacist had reviewed the resident's medication orders on 5/28/13 and 6/24/13 with no Tylenol recommendations. 2. The clinical record was reviewed on 9/5/13 at 8:55 a.m. for Resident # 68. He had diagnoses which included, but were not limited to: hypertension, peripheral neuropathy, insomnia, osteoarthritis, glaucoma, and dementia. The physician rewrite orders for medications, most recently reviewed by the physician on 8/3/13, indicated		Residents Having the Potential to be Affected: All residents taking acetaminophen have the potential to be affected. The medication orders for all residents were reviewed for usage of acetaminophen. Those residents with the potential to exceed 4000mg daily based upon their routine orders in addition to use of every prn dose available were identified. PRN administration was reviewed for these residents over a 30-day period and was calculated with any routine medication doses. There were no instances of exceeding the daily recommended limit of 4000mg. A precautionary medication test with the statement “Do not exceed 4000mg of acetaminophen daily” was added to the EMR system to attach to medications containing acetaminophen. This medication test was added to each medication containing acetaminophen for each of these residents. A care plan for acetaminophen use was added to each resident’s plan of care. (Attachment 12 titled Acetaminophen Warning Care Plan). Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: A medication test with the precautionary statement “Do not exceed 4000mg of acetaminophen daily” was added to the EMR system. During review of new and admission	

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	the resident was receiving Norco 5/325 (5 milligrams [mg.] of Hydrocodone and 325 mg of Tylenol) 1 tablet q4h (every 4 hours) for pain (originally ordered 8/22/12). In addition, there was an order for Tylenol 325 2 tabs q4h prn (as necessary) (originally ordered on 8/22/12). The Medication Administration Record (MAR) for July, 2013, August, 2013, and September, 2013 was reviewed. The resident had received prn Tylenol only once on 7/27/13, 8/6/13, 8/11/13, 8/27/13, and 9/13/13. This was in addition to the 1950 mg of Tylenol with the Hydrocodone. The pharmacist had reviewed the resident's medications on 1/23/13, 2/26/13, 3/18/13, 4/22/13, 5/28/13, 6/25/13, and 8/27/13. There were no recommendations for a precautionary statement on any of the recommendations for any of the Tylenol orders. 3. Interview with the Director of Nursing, on 9/5/13 at 10:30 a.m., indicated she had contacted the pharmacist. She indicated he had indicated he did not recommend a precautionary statement until the resident was close to or over the		orders each business day, DON or designee will assure the medication test with the precautionary statement is attached to any orders for medications containing acetaminophen. An audit of 6 residents per week will be conducted to assure they have not exceeded the recommended daily dosage limit. (Attachment titled 13 Acetaminophen Audit). Nursing staff education was completed beginning September 25, 2013 and will be complete by 10-07-2013. (Attachment 9 titled 2013 Annual Survey Plan of Correction). The pharmacy will review for routine regimens that would exceed the recommended daily acetaminophen dosage limits and notify the facility of any concerns.Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate documentation is completed 100% of the time, weekly audits will be stopped and monthly audits will begin. A sample size of 25% will be completed. If opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100% compliance continues, auditing will stop.	

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	recommended dose. 4. Review of the Nursing 2013 Drug Handbook, from the A Unit of the facility, on page 67, indicated the following: "...Indications and dosages: Adults: 325 to 650 mg every 4 to 6 hours. Or, two extended-release caplets P.O. (by mouth) every 8 hours. Maximum , 4 g (grams) daily. For long term therapy, don't exceed 2.6 g daily unless prescribed and monitored closely by health care provider...." 3.1-25(i)			

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review the facility failed to have a controlled substance/medication (morphine)	F000431	F 431 Drug Records, Label/Store Drugs and Biologicals. It is the policy of this facility to provide separately locked, permanently affixed compartments for storage	10/07/2013

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	stored in a locked narcotic box, in a locked medication cart in 1 of 3 medication carts reviewed for medication storage. Findings include: On 9-5-13, at 7:12 A.M., during on observation of a narcotic count between night shift and day shift nurses, RN#2 and LPN #3 discovered a bottle of morphine was missing from the locked medication cart. LPN #3 indicated she had administered the medication to the resident around 12:30 A.M. At 7:21 A.M. the bottle was discovered by LPN #3 in an open basket on a vital sign cart. LPN #3 indicated she must of left the medication on the vital sign cart when she was monitoring the resident's vital signs before and after administrating the medication. On 9-5-13 at 2:52 P.M. a policy titled " Controlled Substances" indicated "...Controlled substances must be stored in a separately locked container..." in the medication room/cart. During an interview on 9-5-13 at 2:15 P.M., the Director of Nursing indicated that "controlled substances" were to be locked in the lock box in		of controlled medications.Corrective Action for Resident Affected: No residents were affected.Other Residents Having the Potential to be Affected: All residents have the potential to be affected. All medication carts and medication rooms were audited to assure appropriate storage of narcotic medications.Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: Nursing staff in-service provided to review the facility policy for narcotic medication storage. Education begun on September 25, 2013 and will be complete by 10-07-2013. (Attachment 9 titled 2013 Annual Survey Plan of Correction). One medication cart per week will be randomly selected for auditing to assure narcotics are properly stored. (Attachment 18 titled Medication Cart Audit). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate procedure is followed 100% of the time, weekly audits will be stopped and monthly audits will begin. If opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100% compliance continues, auditing will stop.	

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	155715	A. BUILDING 00 B. WING	09/10/2013

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	the nurse's locked cart. 3.1-25(n)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to accurately document pressure ulcers for 1 of 19 residents reviewed for accurate documentation. (Resident #117) Findings include: Resident #117's closed clinical record, with the admission date of 3/30/13, was reviewed on 9/4/13 at 3:26 p.m. Admitting diagnoses included, but were not limited to, atrial fibrillation, anxiety state, depressive disorder, hypertension (high blood pressure), and anemia. Resident #117's "Admission Observation", dated 3/31/13, partially indicated, "Left Heel: Pressure ulcer" and "Right	F000514	F 514 Records - Complete and Accurate Documentation. It is the policy of this facility to maintain clinical records that are complete; accurately documented; readily accessible; and systematically organized.Corrective Action for Resident Affected: Resident #117 had already been discharged from the facility.Other Residents Having the Potential to be Affected: Each resident with a pressure area has the potential to be affected. Documentation was reviewed for each resident having a pressure area over a 30-day period and any inconsistencies were addressed with the nursing staff involved.Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: Nursing staff education was initiated on September 25, 2013 and will be completed by 10-07-2013. Staff will begin to only document	10/07/2013

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	Heel: Pressure Ulcer." A review of "Skin Condition Report Without Images" documentation from 3/31/13 - 5/13/13, and provided by the Director of Nursing (DON) on 9/5/13 at 9:15 a.m., indicated that Resident #117's right and left heel pressure ulcers were intermittently documented as "present on admission" and "not present on admission" throughout multiple documentation dates. Examples include, but are not limited to: - "3/31/2013 2:33:51AM New (1st recording) for site-488. Present on the Right Heel is a Pressure Ulcer...This wound was present on admission." - "3/31/2013 2:34:50AM New (1st recording) for site-408. Present on the Left Heel is a Pressure Ulcer...This wound was present on admission." - "4/1/13 5:30:00PM Skin and Wound update to Site-408. Present on the Left Heel is a Pressure Ulcer...This wound was not present on admission." - "4/1/13 11:30:00PM Skin and Wound update to Site-488. Present on the Right Heel is a Pressure Ulcer...This wound was not present		whether or not a wound was present on admission for the initial entry. This will help to eliminate a discrepancy in this area. The skin and wound documentation workflow was updated to reflect this change. (Attachment 19 titled Skin/Wound, Daily Pressure Ulcer Documentation). The DON or designee will review/audit the documentation of each resident with a pressure ulcer on a weekly basis to assure there are no inconsistencies in documentation as to whether or not a wound was present upon admission. (Attachment titled 20 Weekly Wound Documentation Audit). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate documentation is completed 100% of the time, weekly audits will be stopped and monthly audits will begin. A sample size of 25% will be completed. If opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100% compliance continues, auditing will stop.	

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	on admission." - "4/2/13 4:18:50AM Skin and Wound update to Site-408. Present on the Left Heel is a Pressure Ulcer...This wound was present on admission." - "4/2/13 4:20:05AM Skin and Wound update to Site-488. Present on the Right Heel is a Pressure Ulcer...This wound was present on admission." In an interview with the Administrator, on 9/5/13 at 2:14 p.m., she indicated, "I can't say for sure why there was a discrepancy." She further indicated that both pressure ulcers were present on admission. 3.1-50(a)(2)			

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F009999	3.1-25 Pharmacy Services (j) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This state rule was not met as evidenced by: Based on observation, interview and policy review the facility failed to label over-the-counter medications, with the orders received from physician, for administration in 1 of 5 residents reviewed during a medication pass. (Resident #98) Findings include: On 9-5-13, at 8:20 A.M., LPN #4 was observed preparing medications for Resident #98. The over- the-counter medications: Vitamin D, a multi-vitamin, and Fish Oil had been labeled with resident's name. The label did not include directions for use of the medication that included: name of drug, dosage and time of	F009999	F 9999 Pharmacy Services. It is the policy of this facility to label over-the-counter medications, prescription drugs, and biological in accordance with currently accepted professional principles.Corrective Action for Resident Affected: All medications for resident #98 were checked and labeled according to facility policy.Other Residents Having the Potential to be Affected: All residents have the potential to be affected. All medication carts and medication rooms were audited to assure appropriate labeling of over-the-counter/brought from home medications.Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: Nursing staff in-service provided beginning September 25, 2013 and will be complete by 10-07-2013 to review the facility policy for labeling of over-the-counter/brought from home medications. Staff were educated to assure medications are labeled at the time they are brought in to the building. (Attachment 9 titled 2013 Annual Survey Plan of Correction). One medication cart per week will be randomly selected for auditing to assure appropriate labeling. (Attachment 18 titled Medication Cart Audit). Monitoring of Corrective Action: Audit results will be reviewed by the Quality	10/07/2013

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	administration as directed by the physician. During an interview, on 9-5-13 at 2:02 P.M., the Director of Nursing indicated that all medications should be labeled with resident's name and directions for usage according to the physician's orders. On 9-5-13 at 2:25 P.M., a policy titled "Labeling of Medication Containers" was reviewed and indicated "...Labels for over-the -counter drugs include: a. The original label; The resident's full name; The expiration date when applicable; and Directions for use and appropriate accessory/cautionary statements...." 3.1-25(j)		Assurance Committee monthly for six months. If appropriate procedure is followed 100% of the time, weekly audits will be stopped and monthly audits will begin. If opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100% compliance continues, auditing will stop.	

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R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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R000091	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to implement the written policy for resident discharges for 1 of 2 residents reviewed for discharged. (Resident #41) Findings include: A record review of Resident #41's closed record review was conducted on 9/9/13 at 2:20 p.m. The record indicated Resident #41 was admitted on 12/1/11, and admitting diagnoses included, but were not limited to, diabetes, osteoarthritis and hypertension. Resident #41 was discharged to home on 6/14/13. No discharge documentation was located. In an interview with the Nurse Manager, on 9/9/13 at 2:30 p.m., she	R000091	R 091 Administration and Management. It is the policy of this facility to establish and implement written policies. Corrective Action for Resident Affected: Resident #41 has already been discharged from the facility. Other Residents Having The Potential to be Affected: All residents have the potential to be affected upon discharge. Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: Nursing education was provided and will be complete by 10-07-2013 to educate the staff on all of the necessary components and documentation required with a discharge of the resident from the facility. (Attachment 1 titled Discharge/Transfer Education). A discharge/transfer form was developed to guide staff documentation. (Attachment 2 titled Discharge/Transfer). The Assisted Living Nurse Manager will audit all discharge records to ensure that the appropriate	10/07/2013

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	indicated that there was no "discharge paperwork" for Resident #41. She further indicated "She went home with her son and he already knew what kind of meds she took." A review of the "Discharge/Transfer" Policy provided by the Nurse Manager 9/10/13 at 10:30 a.m., included, but was not limited to, the following: - "Should the resident be transferred or discharged for the following reasons, the basis for the transfer or discharge must be documented in the resident's clinical record by the resident's attending physician: a. The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility...." - "Documentation from the care planning team concerning all transfers or discharges must include, as a minimum, and as they may apply: a. The reason(s) for the transfer or discharge; b. That an appropriate notice was provided to the resident and/or representative (sponsor); c. That the resident and/or representative (sponsor) participated in a predischarge orientation program; d. The date and time of the		process was followed and the appropriate documentation occurred. (Attachment 3 titled Admission/Discharge Audit). Monitoring of Corrective Action : Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate documentation is completed 100% of the time, random audits will begin. A sample size of 25% will be performed. If opportunities for improvement are identified through the random audit, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop.	

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	transfer or discharge; e. The new location of the resident; f. The mode of transportation; g. A summary of the resident's overall medical, physical, and mental condition; i. Disposition of medications; j. Others as appropriate or as necessary; and k. The signature of the person recording the data in the medical record." - "A post-discharge plan is developed prior to the discharge or transfer." The "Discharge/Transfer" Policy (above) was reviewed with the Nurse Manager, on 9/10/13 at 11:30 a.m., and she indicated that she could not provide discharge documentation for Resident #41 as outlined per the facility policy. She provided a copy of the "Resident Data Sheet", dated 11/31/10, which had a discharge summary hand-written on the back, dated 6/14/13. She indicated the physician signature under the notation "Complete on Discharge of Patient." A review of Physician Orders, dated 6/14/13, and provided by the Nurse Manager 9/10/13 at 12:45 p.m., indicated, "Discharge from assisted living 1 time per day during Day...."			

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	Review of "Progress Notes by Resident", dated 6/12/13 at 10:44 a.m., and provided by the Nurse Manager, on 9/10/13 at 11:30 a.m., indicated, "This nurse spoke with resident's son and POA and he said the family has decided to move resident to another facility instead of moving her to nursing unit here...the family will be here to move her on Friday morning. [Resident's son] states he spoke with resident last evening about this move. This nurse spoke with her doctor and informed him of the details - that we will be keeping her here until Friday morning. MD agreed this is ok." Review of "Progress Notes by Resident", dated 6/14/13 at 3:03 p.m., and provided by the Nurse Manager, on 9/10/13 at 11:30 a.m., indicated, "Resident's son [Name of son], also POA for resident here to pick up resident from the facility...resident walked out of the building with her son using a walker at this time. Resident discharged from assisted living due to increasing dementia and needing more nursing care."			

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R000409	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure 7 residents, in a sample of 7, had a health statement that included a statement that the resident was free of tuberculosis in an infectious state. (Resident's #5, #7, #14, #29, #31, #40, #41) 1. Record review, on 09/09/13 at 2:00 p.m., for Resident #31, indicated a physical assessment, dated 07/17/13, that did not include a statement that Resident #31 is free of tuberculosis in an infectious state. 2. Record review, on 09/09/13 at 3:00 p.m., for Resident #5, indicated a physical assessment, dated 04/22/13, that did not include a statement that Resident #5 is free of tuberculosis in an infectious state. 3. Record review, on 09/09/13 at 2:30 p.m., for Resident #14, indicated	R000409	R 409 Infection Control. It is the policy of this facility that prior to admission, each resident shall be required to have a health assessment, including history of significant and past infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.Corrective Action for Resident Affected: Residents #29, 31, 14, 5, 7, 40, and 41 have had the appropriate annual statement “Patient is free of communicable disease including infectious TB” signed by their physician.Other Residents Having the Potential to be Affected: All residents of the facility have the potential to be affected. All residents have had the appropriate annual statement “Patient is free of communicable disease including infectious TB” signed by their physician.Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: The statement “Patient is free of communicable disease including infectious TB” will be added to the	10/07/2013

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	a physical assessment, dated 09/25/12, that did not include a statement that Resident #14 is free of tuberculosis in an infectious state. 4. Record review, on 09/10/13 at 9:10 a.m., for Resident #7 indicated a physical assessment, dated 07/17/13, that did not include a statement that Resident #7 is free of tuberculosis in an infectious state. 5. Record review, on 09/9/13 at 2:00 p.m., for Resident #29, indicated a physical assessment, dated 11/12/12, that did not include a statement that Resident #29 is free of tuberculosis in an infectious state. 6. Record review, on 09/09/13 at 2:30 p.m., for Resident #41, indicated a physical assessment, dated 08/11/12, that did not include a statement that Resident #41 is free of tuberculosis in an infectious state. 7. Record review, on 09/09/13 at 2:10 p.m., for Resident #40, indicated a physical assessment, dated 06/22/12, that did not include a statement that Resident #7 is free of tuberculosis in an infectious state. During an interview, on 09/10/13 at 10:33 a.m., the Nurse Manager		Annual Physical Form signed by the physician. (Attachment 16 titled Annual Physical Form). The Assisted Living Nurse Manager will complete an audit of all new admissions to ensure that the form is completed accurately. (Attachment 17 titled Yearly Physician Form Audit). Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If appropriate documentation is completed 100% of the time, random audits will occur monthly. A sample size of 25% will be completed. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of random audits 100% compliance continues, auditing will stop.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, "We don't do that here" in regards to the annual health statement. On 09/10/13 at 2:26 p.m., the Annual Physical Assessment policy statement (effective 02/01/10) was provided by the Nurse Manager. The third sentence of the policy indicates, "...3. The annual Physical health assessment will include a history of significant past or present infectious diseases...."			